EXHIBIT B

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

PHS

Form must be Complete and Legible. You must Type or Print

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

DEMOGRAPHICS

Site Name & Number:	Patient Name: (Last, First,)	Date: (mm/dd/yy)
VENTRESS-0845	Stnek land Willie	06/14/04
Site Phone #	**Alias: (Last, First,)**	**Date of Birth: (mm/dd/yy)**
334-7758178		[redacted]
Site Fax #	**Inmate #**	**PHS Custody Date: (mm/dd/yy)**
334-775-8178	226537	01/21/03
Will there be a charge? ☐ Yes ☐ No / **Sex** ☐ Male ☐ Female	**SS Number** [redacted]	**Potential Release Date: (mm/dd/yy)** 12/8/09

Responsible party: ☐ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare and Medicaid):

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP, PA ☐ Dental

Dr Samuel Ray apeth.

Facility Medical Director Signaure and Date:

Samuel Ray apeth. M.D.

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☑ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)
☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☐ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) ___/___/___

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy

Number of Visits/Treatments: _____ ☐ Other:_____

Specialist referred to: Surgery

Type of Consultation, Treatment, Procedure or Surgery:

Eval for Surgery of a Small RIH - Benign and reducible.

History of illness/injury/sypmtoms with Date of Onset:

A month ago a small RIH - easily reducible only visible on long standing and easily reduced on supine position diagnosed

Results of a complaint directed physical examination:

Small RIH - easily reducible Non-Tender - with no Significant dilatation of Right inguinal ring - no other Complications

Previous treatment and response (including medications):

Will soon a Truss will be supplied - But in Stats he will be more Comfortable with Surgery

IH Has BBB - And Lay in profile

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

*****For security and safety, please do not inform patient of possible follow-up appointments*****

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CONFIDENTIAL RECORD
NOT TO BE PHOTO COPIED

UM DETERMINATION:

☐ Offsite Service Recommended and Authorized

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

Returned Denied 6-16-04

Date resubmitted: ___/___/___

☐ Resubmitted with requested information.

Regional Medical Director Signature, printed name and date required:

___/___/___ (mm/dd/yy)

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:	Med Class:	UR Auth #:

Received 6-16-04